WEBER
FACIAL PLASTIC SURGERY

Patient Information

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
DOB: _____ Sex ❑ F ❑ M
SSN: _____
Marital Status: _____
Home Phone: (____) _____
Cell Phone: (____) _____
E-Mail Address: _____
Occupation: _____
Employer: _____
Work Phone: (____) _____
Address: _____
City: _____ State: _____ Zip: _____

Family Doctor Name: _____
Office Phone: (____) _____
Address: _____
City: _____ State: _____ Zip: _____
Pharmacy Name: _____
Pharmacy Phone: (____) _____
Address: _____
City: _____ State: _____ Zip: _____

Primary Insurance Company

Was this ACCIDENT RELATED ❑ Yes ❑ No
Name of Insurance Co.: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (_____) _____
ID # _____
Group # _____
Claim # _____
Cardholder Name: _____
SSN: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (_____) _____
Employer: _____

Contact In Case Of Emergency

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
DOB: _____ SSN: _____
Home Phone: (____) _____
Cell Phone: (____) _____
Work Phone: (____) _____

How were you referred to our office?

❑ Doctor: _____
Phone: (_____) _____
❑ Family: _____
❑ Friend: _____
❑ Internet: _____
❑ Insurance Book ❑ Magazine ❑ Newspaper

Personal Medical History

Age: _____ Height: _____ Weight: _____

Drug Allergies? ❑ No ❑ Yes Reactions
1) _____ _____
2) _____ _____
3) _____ _____

Current Medications Dosages
1) _____ _____
2) _____ _____
3) _____ _____

Are you on any medications containing ASPIRIN?
❑ No ❑ Yes Dosage: _____

Previous Surgical Procedures Date(s)
1) _____ _____
2) _____ _____
3) _____ _____

Major Illnesses - (CIRCLE)

N/A High Blood Pressure Diabetes Cancer
Lung Disease Heart Disease
Kidney / Liver Problems Other _____

Do you or any family members have a history of
❑ Easy Bruising ❑ Excessive Bleeding

Do you or any family members have a history of anesthesia issues (high fever, slow to emerge)?
❑ No ❑ Yes: _____
Are you pregnant? ❑ No ❑ Yes

Smoker? ❑No ❑Yes How many packs per day ____
For how long? ____Years ____Months
If you have quit, for how long? ____Years ____Months

Alcohol? ❑ No ❑ Yes If Yes, how many servings ____ per day? ____ For how long? ____Years ____Months

I certify that the above information is accurate.

X: _____ Date: _____

10463 Park Meadows Dr., Suite 110
Lone Tree, Colorado 80124

Stephen Weber MD, FACS

Office (303) 792-2224 Fax (888) 378-4980
www.weberfacialplasticsurgery.com

WEBER
FACIAL PLASTIC SURGERY

Trust your face to an expert.

Phone/ E-mail Message Consent

Your physician will at times need to contact you. By filling out the information below, we will be better able to serve you.

In an effort to protect your privacy and follow new federal guidelines, we have developed a policy on leaving medical care messages:

- We will NOT leave messages with anyone except the patient or legal guardian
- We will NOT leave messages on voice mail or answering machine or e-mail **UNLESS WE HAVE WRITTEN PERMISSION TO DO SO**

Please read below and consider carefully whom you want to have access to your medical/account information.

I, _____ give Weber Facial Plastic Surgery permission to leave phone messages and/or e-mail messages regarding my medical care/account/promotional information with the following. I understand that this consent will remain valid until revoked in writing by me.

May we leave a message?

HOME PHONE: _____ **Yes or No**

WORK PHONE: _____ **Yes or No**

CELL PHONE: _____ **Yes or No**

TEXT MESSAGE: _____ **Yes or No**

EMAIL ADDRESS: _____ **Yes or No**

Whom may we speak to on your behalf?

Partner Yes No If yes, name: _____

Son or Daughter Yes No If yes, name: _____

Friend/Neighbor Yes No If yes, name: _____

Other Yes No If yes, name_____

Special Notes: _____
_____

SIGNATURE: _____ DATE: _____

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FINANCIAL POLICY

At Weber Facial Plastic Surgery, PC we are committed to providing you with the best possible care. We are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policies is important to our professional relationship.

- **If you are unable to keep a scheduled appointment with our office, kindly give at least 24 hour notice.**
- **We DO NOT bill insurance companies for cosmetic procedures.** Initial _____
- **In order to reserve the operating room and the physician's time, a refundable scheduling and booking fee is required upon scheduling.** Initial _____
- **The balance of your surgical fees for Dr. Weber including facility and anesthesia charges (if applicable) must be paid in full at your pre-operative appointment.** Initial _____
- **The surgical fees include twelve months of routine post-operative care.**
- **Dr. Weber's time, as well as that of the operating room staff, is scheduled in advance. If an emergency arises and you feel the need to postpone your surgery, please notify the office as soon as possible. We require documentation for all cancellations made in the case of an emergency or health issue.**
- **Fees for any outside lab work (blood work, EKG, x-rays, etc.) are your responsibility.**
- **Quotes for surgical fees are valid for 90 days from the date of your initial consultation.**
- **There is a $35.00 charge for returned checks.**
- **Should your account become delinquent, you will be responsible for all costs incurred in collecting the account, including court costs and attorney fees.**

Thank you for taking the time to fully understand our financial policies. Please let us know if you have any further questions or concerns.

I certify that I understand and agree to the financial obligations outlined above.

_____ _____ _____ _____

Patient Signature **Date** **Witness** **Date**

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INSURANCE POLICY

At Weber Facial Plastic Surgery, we provide consultations for elective, cosmetic procedures as well as procedures that will involve full or partial coverage by medical insurance.

We accept insurance for procedures to treat facial trauma, skin cancer and nasal obstruction. To determine whether insurance will cover the procedure(s) that you require, a physician visit will be conducted by Dr. Weber and billed to your insurance company. Your co-payment or co-insurance will also be collected upon check out following your visit.

It is our pleasure to try to obtain pre-authorization from your insurance carrier for specific procedures. In many cases, we are able to confirm that a procedure is covered by your insurance carrier. However, all out of pocket and co-insurance fees associated with your procedure must be determined between you and your insurance carrier. We are happy to provide typical billing codes to help you determine these fees with your insurance carrier.

Thank you for taking the time to fully understand our insurance policy. Your clear understanding of these policies is important to our professional relationship. Please let us know if you have any further questions or concerns.

I certify that I understand and agree to the insurance policy outlined above.

_____ _____ _____ _____

Patient Signature **Date** **Witness** **Date**

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RECEIPT OF NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT FORM

I hereby acknowledge that on _____ I received the Notice of Privacy Practices from Weber Facial Plastic Surgery, which sets forth the ways in which my personal health information may be used or disclosed by Weber Facial Plastic Surgery, and outlines my rights with respect to such information.

I authorize the release of any information acquired in the course of my examination or treatment if necessary to determine benefits.

_____

Patient Signature **Date**

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